FILED

July 24, 2009

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

In the Matter of:

ROSE MARIE KUNASZUK, C.N.M.

CONSENT ORDER

This matter was opened before the New Jersey State Board of Medical Examiners (the "Board") upon the Board's receipt of information detailing that a payment of $350,000 had been made on behalf of respondent Rose Marie Kunaszuk, C.N.M., to settle a civil malpractice action brought against her by patient K.A. The civil suit was predicated upon allegations that respondent failed to timely inform her affiliated physician of a poor fetal heart rate tracing, which in turn led to a birth injury and ultimate death of K.A.'s infant child.

The Committee had opportunity to review the patient records that were maintained by C.N.M. Kunaszuk and her affiliated physicians for K.A. and relevant hospital records to include the hospital record for K.A.'s admission for delivery on February 11, 2005. The Committee additionally considered testimony offered by respondent when she appeared before the Committee, represented by Thomas Reynolds, Esq., for an investigative hearing on December 15, 2008.

Upon review of available information, the Committee found that K.A., a patient who had delivered her previous child by cesarean section, was admitted to Virtua/West Jersey Hospital in early labor on February 11, 2005. K.A. requested and consented to a trial of labor, at which time pitocin induction began. After a prolonged second stage of labor, K.A.'s obstetric physician attempted delivery by a vacuum extraction at approximately 5:30 a.m. on February 12. After the attempt at vacuum extraction was unsuccessful, delivery was accomplished by cesarean section. The infant required immediate resuscitation, and Apgar scores of 1,2 and 3 were recorded at one, five and ten minutes, respectively. The infant was transferred to a specialty hospital where he expired on February 13, 2005. The death certificate stated that the infant died of multi-system organ failure and subgaleal hemorrhage.

Respondent participated in the management of K.A.'s course of labor, and was the sole care provider between 10:50 p.m. on February 11, 2005 and approximately 4:30 a.m. on February 12, 2005. Respondent testified that, during that time period, she contacted her affiliated physician one time, at approximately 3:15 a.m., and then asked her to come to the patient's hospital room. Respondent's affiliated physician did not in fact arrive until 4:30 a.m.

Upon review of all available information, the Committee

concluded that respondent engaged in multiple acts of negligence during the period that she provided intrapartum midwifery care to K.A. as the sole care provider - specifically, between 10:50 p.m. on February 11, 2005 and 4:30 a.m. on February 12, 2005. Most significantly, the Committee found that there were multiple instances where the fetal heart rate tracings were non-reassuring and/or suspicious for fetal distress. Based on those tracings, the Committee concluded that respondent should have contacted her affiliated physician prior to 3:15 a.m., should have specifically advised her affiliated physician of concerns with the fetal heart rate tracings, and should have made repeated efforts to ensure the physician's presence prior to 4:30 a.m. The Committee found that respondent was also negligent in her failure to have concluded that K.A. (who was on pitocin for the entire period) was being hyperstimulated. Finally, the Committee found that respondent was negligent by failing to follow the requirements of her own protocols, which would have required her to have made more frequent chart entries and to have contacted her affiliated physician more promptly.

The Committee additionally found that respondent violated the requirements of N.J.A.C. 13:35-6.5 by failing to adequately document the care she provided, and pertinent findings, within K.A.'s hospital chart. It is thus the case that, during the entire time that respondent managed the care of K.A., she made

only one entry in the progress notes section of the hospital chart at 00:50 on February 12.

The Board herein adopts the findings of fact made by the Midwifery Committee. Based thereon, the Board concludes that cause for disciplinary action against respondent exists pursuant to N.J.S.A. 45:1-21(d) and 45:1-21(h). The parties desiring to resolve this matter without need for formal disciplinary proceedings, and the Board being satisfied that the need for such proceedings is obviated by the entry of the within Order, and being further satisfied that good cause exists to support the entry of the within Order,

IT IS on this 23rd day of July, 2009

ORDERED and AGREED:

1. Respondent Rose Marie Kunaszuk, C.N.M., is hereby reprimanded for having engaged in repeated acts of negligence when providing care to patient K.A., and for having failed to adequately document K.A.'s hospital chart.

2. Respondent is assessed a civil penalty in the amount of $5,000, which penalty shall be paid in full at the time of entry of this Order.

3. Respondent shall attend and successfully complete, within six months of the date of entry of this Order, a continuing education course in the interpretation of fetal heart rate tracings. Respondent shall obtain pre-approval from the Board for

any course she intends to take to satisfy the requirements of this paragraph. Respondent shall additionally be responsible to ensure that documentation is provided to the Board by the course provider, at the conclusion of the course, attesting to respondent's attendance and successful completion of the course.

4. Respondent shall attend and successfully complete, within six months of the date of entry of this Order, a continuing education course in record-keeping. Respondent shall obtain pre-approval from the Board for any course she intends to take to satisfy the requirements of this paragraph. Respondent shall additionally be responsible to ensure that documentation is provided to the Board by the course provider, at the conclusion of the course, attesting to respondent's attendance and successful completion of the course.

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

By: _____
Paul C. Mendelowitz, M.D.
Board President

I consent to the entry of this Order by the State Board of Medical Examiners

Rose Marie Kunaszuk, C.N.M. 7/8/09

NOTICE OF REPORTING PRACTICES OF BOARD REGARDING DISCIPLINARY ACTIONS

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

(1) Which revokes or suspends (or otherwise restricts) a license,
(2) Which censures, reprimands or places on probation,
(3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license(and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A.45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.